

(Complete all questions. Please contact your physician for assistance if necessary.)

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Form No. \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Were you diagnosed with any of the following conditions? Check all that apply.

**Crohn's disease.** Date of first episode: \_\_\_\_\_ Date last treated: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_  
Number of attacks you have had since this condition was first diagnosed: \_\_\_\_\_ Duration of attack (such as hours, days,  
weeks or months): \_\_\_\_\_ Names of medications, include amount taken per day and how often per day: \_\_\_\_\_

**Enteritis (inflammation of the lining of the small intestine)** Date of first episode: \_\_\_\_\_ Date last treated: \_\_\_\_\_  
Number of episodes in the last year: \_\_\_\_\_ Number of attacks you have had since this condition was first diagnosed: \_\_\_\_\_  
Duration of attack (such as hours, days, weeks or months): \_\_\_\_\_ Names of medications, include amount taken per  
day and how often per day: \_\_\_\_\_

**Ulcerative colitis.** Date of first episode: \_\_\_\_\_ Date last treated: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_  
Number of attacks you have had since this condition was first diagnosed: \_\_\_\_\_ Duration of attack (such as hours, days,  
weeks or months): \_\_\_\_\_ Names of medications, include amount taken per day and how often per day: \_\_\_\_\_

**Irritable bowel/spastic colon.** Date of first episode: \_\_\_\_\_ Date last treated: \_\_\_\_\_  
Number of episodes in the last year: \_\_\_\_\_ Number of attacks you have had since this condition was first diagnosed: \_\_\_\_\_  
Duration of attack (such as hours, days, weeks or months): \_\_\_\_\_  
Names of medications, include amount taken per day and how often per day: \_\_\_\_\_

**Diverticulosis (pouchlike herniations in the colon)** Date of first episode: \_\_\_\_\_ Date last treated: \_\_\_\_\_  
Number of episodes in the last year: \_\_\_\_\_ Number of attacks you have had since this condition was first diagnosed: \_\_\_\_\_  
Duration of attack (such as hours, days, weeks or months): \_\_\_\_\_ Names of medications, include amount taken per  
day and how often per day: \_\_\_\_\_

**Diverticulitis (inflammation/abcess formation in the tissues surrounding the colon)** Date of first episode: \_\_\_\_\_  
Date last treated: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_ Number of attacks you have had since this condition  
was first diagnosed: \_\_\_\_\_ Names of medications, include amount taken per day and how often per day: \_\_\_\_\_

**Polyps.** Date of first episode: \_\_\_\_\_ Date last treated: \_\_\_\_\_ Number of episodes in the last year: \_\_\_\_\_  
Number of attacks you have had since this condition was first diagnosed: \_\_\_\_\_ Duration of attack (such as hours, days,  
weeks or months): \_\_\_\_\_ Names of medications, include amount taken per day and how often per day: \_\_\_\_\_

Please list any diagnosis other than above: \_\_\_\_\_

2. How would you describe your symptoms when an attack occurs? Please check all that apply.

Mild     Mild to Moderate     Moderate to Severe     Severe

3. Have you had any of the following tests? Check all that apply.  
 Blood test       Barium enema       Sigmoidoscopy       Biopsy       Colonoscopy  
 If yes, give dates of testing and results: \_\_\_\_\_  
 \_\_\_\_\_
4. Do you have a colostomy or ileostomy?  Yes  No If yes, on what date was this procedure performed? \_\_\_\_\_
5. Have you ever been hospitalized or had surgery for an intestinal related illness/condition?  Yes  No If yes, please provide details of hospitalization and give date and type of surgery: \_\_\_\_\_  
 \_\_\_\_\_
6. Have you ever taken, or been advised to take any type of steroids or azulfidine/sulfasalazine?  Yes  No  
 If yes, give name(s) of medication(s) and date(s) taken: \_\_\_\_\_  
 \_\_\_\_\_
7. Have you lost weight in the last 12 months?  Yes  No If yes, how many pounds? \_\_\_\_\_
8. Please list your exact current height: \_\_\_\_\_ weight: \_\_\_\_\_
9. Name and address of treating physician: \_\_\_\_\_  
 \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand American Community will rely on these statements when determining eligibility.

\_\_\_\_\_  
 Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
 Date